



## Authorization to Obtain Your Medical Records

Authorization is needed for us to obtain your medical records and have them sent to our office. Please specify which records you would like sent to our office so that we may most effectively participate in your care.

### Patient information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_\_\_ Phone#: (\_\_\_\_\_) \_\_\_\_\_

### Authorization:

I authorize the release of my medical information from \_\_\_\_\_  
\_\_\_\_\_ to be sent to Central Minnesota Dermatology.

### Please select the information you would like to release:

- |                                                 |                                          |
|-------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> All records            | <input type="checkbox"/> Visit notes     |
| <input type="checkbox"/> Histopathology reports | <input type="checkbox"/> Imaging reports |
| <input type="checkbox"/> Laboratory reports     | <input type="checkbox"/> Pictures        |

Other: \_\_\_\_\_

### Purpose of the disclosure:

- |                                             |                                                   |
|---------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Continuity of care | <input type="checkbox"/> Insurance                |
| <input type="checkbox"/> Legal              | <input type="checkbox"/> Disability determination |
| <input type="checkbox"/> Personal use       | <input type="checkbox"/> Other: _____             |

### Please send the selected records to:

Central Minnesota Dermatology  
1903 S 6<sup>th</sup> Street, Suite 3  
Brainerd, MN 56401  
Phone: 218-454-3376  
Fax: 218-454-4263

### Authorization Statements/Signatures:

1. I acknowledge that by signing this form, I have read and understand the above information and I authorize the release of the stated information.
2. I understand that the authorization lasts for one year from the date signed unless cancelled in writing.
3. I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to Central Minnesota Dermatology. I understand that the revocation will not apply to any information that has already been released in response to the authorization.
4. I understand that Central Minnesota Dermatology will not condition the provision of treatment or payment on the provision of this authorization.

Signature of Patient / Legal Representative: \_\_\_\_\_

Date: \_\_\_\_\_ If not Patient: Parent: \_\_\_\_\_ Guardian: \_\_\_\_\_ POA: \_\_\_\_\_